TEXAS DEPARTMENT OF HEALTH
BREAST AND CERVICAL CANCER TREATMENT ACT

Frequently Asked Questions

Question 1. What are the eligibility requirements for the new optional eligibility group for women who need treatment for breast or cervical cancer?

Answer. In order to qualify under this new optional category, a woman must meet the following eligibility requirements:

1. The woman must have been screened for breast or cervical cancer under the Centers for Disease Control and Prevention (CDC) Breast and Cervical Cancer Early Detection Program established under the Title XV of the Public Health Service Act, and found to need treatment for either breast or cervical cancer (including a pre-cancerous condition);
2. She does not otherwise have other creditable coverage. The term "creditable coverage" means a woman cannot have a group health plan, benefits consisting of medical care under any hospital or medical service policy, Medicare, Medicaid, armed forces insurance, or state health risk pool; and
3. She is under age 65.

Question 2. Must a woman be uninsured for a specific length of time before she may be found eligible for Medicaid under the treatment act?

Answer. No. There are no requirements imposed by federal law that there be a waiting period of prior uninsured status before a woman can become eligible for Medicaid under this new option, and states have no authority to impose such requirements. In addition, if she were insured but her creditable coverage were to end, the woman would become immediately eligible for coverage under Medicaid assuming she satisfied all other eligibility criteria.

Question 3. Who is considered to have been "screened for breast or cervical cancer under the CDC Breast and Cervical Cancer Early Detection Program?"

Answer. A woman is considered screened under the CDC program if her clinical services were provided all or in part by CDC Title XV funds. CDC Title XV grantees are those entities receiving funds under a cooperative agreement with CDC to support activities related to the National Breast and Cervical Cancer Early Detection Program. In Texas, the CDC Program is administered by the Texas Department of Health Breast and Cervical Cancer Control Program (BCCCP).

Question 4. What is meant by the term "need treatment"?

Answer. A woman is considered to "need treatment" if, in the opinion of the woman's treating health professional, the screening and diagnostic evaluations indicate that the woman is in need of cancer treatment services. These services include diagnostic services that may be necessary to

determine the extent and proper course of treatment, as well as definitive cancer treatment itself. Based on the physician's plan-of-care, women who are determined to require only routine monitoring services for a pre-cancerous breast or cervical condition (e.g., breast examinations and mammograms) are not considered to need treatment.

Question 5. If a state elects to expand Medicaid eligibility to include this optional group, what is the effective date of the coverage available to this group?

Answer. There is no requirement that there be a waiting period of prior uninsured status before a woman who has been screened under the BCCCP can become eligible for Medicaid under this new option.

Medicaid eligibility can be effective as early as the first day of the quarter in which the state Medicaid agency submits an approvable state plan amendment to the Centers for Medicare and Medicaid Services and the state implements the expansion or a later date specific in the state plan amendment.

Question 6. When would a woman's eligibility under this new option end?

Answer: A woman determined eligible under this option would continue to be eligible as long as she is receiving treatment for breast or cervical cancer, is under age 65, and is not otherwise covered under creditable insurance. In Texas, the Department of Human Services (DHS) is responsible for continued eligibility and re-determination requirements.

Question 7. What is the scope of coverage under this option?

Answer. During the period of eligibility, a woman is entitled to full Medicaid coverage as specified in the state plan. Coverage is not limited to treatment of breast or cervical cancer (including pre-cancerous condition). A woman who qualifies for emergency services is not eligible for full Medicaid medical benefits, only emergency services.

Question 8. What is presumptive eligibility?

Answer. Presumptive eligibility is a Medicaid option that allows states to enroll women in Medicaid for a limited period of time before full Medicaid applications are processed, based on a determination by a Medicaid provider of likely Medicaid eligibility. Under presumptive eligibility, a woman has immediate access to services for breast or cervical cancer.

Question 9. When does presumptive eligibility begin?

Answer. Presumptive eligibility begins on the date that a qualified entity determines that the woman appears to meet the eligibility criteria for treatment under the Breast and Cervical Cancer Treatment Act. Federal financial participation is allowed for services provided during this presumptive eligibility period regardless of whether the woman is later found eligible for Medicaid.

Question 10. Are qualified and non-qualified aliens eligible for the Medicaid services?

Answer: The rules that govern citizenship and alienage apply to women eligible under the treatment act. In Texas, legal permanent residents who arrived in the United States after August 21, 1996 are barred from receiving Medicaid. DHS is responsible for alienage determination. Non-qualified aliens may receive Medicaid coverage for treatment of an emergency medical condition. Again, DHS will be responsible for making the determination based on the application provided by the contractor/provider and certification of an emergency condition from a Medicaid provider. The BCCCP contractor/provider should complete the medical assistance form and forward it to DHS for eligibility determination. In this case, the woman would not be presumed eligible for services.

Question 11. What does the term "emergency medical condition" mean?

Answer. The term "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in (A) placing the patient's health in serious jeopardy; (B) serious impairment of bodily functions; or (C) serious dysfunction of any bodily part.

Question 12. Would treatment for breast and cervical cancer (including treatment for a pre-cancerous condition) be classified as coverage for an "emergency medical condition?"

Answer. Breast or cervical cancer may be identified at various stages. Some women in need of treatment for breast or cervical cancer will have an emergency medical condition. As with other examples of emergency medical conditions, medical judgment and the facts of a particular case will form the basis for identifying those conditions in screened women that amount to an emergency medical condition.

Question 13. Is there an age requirement for services under the treatment act?

Answer. The woman must not have reached her 65th birthday. The contractor/provider will follow BCCCP program eligibility guidelines.

Question 14. Is there a minimum residency requirement?

Answer. The woman must be a resident of Texas. There are no minimum residency requirements. If the woman states she is from another state and visiting Texas, she would not be eligible for Medicaid services.

Question 15. Are medical bills unrelated to the cancer diagnosis covered by Medicaid?

Answer. Yes, the woman is eligible for full Medicaid benefits covered under the Texas Medicaid program. All eligible medical bills are covered from the date of diagnosis. Dependent medical bills are not covered under the program, only the BCCCP client's medical bills.

Question 16. How does the contractor/provider know if a client qualifies for Medicaid services for an emergency condition?

Answer. If in doubt, the contractor/provider forwards the application to the DHS for eligibility determination.

Question 17. Does the BCCCP require proof of income? What constitutes proof?

Answer. The BCCCP central office allows contractors to determine how to document income, and does not define "proof." Most contractors/providers allow clients to self-report income, although some agencies have stricter requirements for proof of income.

Question 18. Will BCCCP require proof of U.S. citizenship?

Answer. As part of the eligibility determination process for Medicaid, the BCCCP contractor/provider should screen for U.S. citizenship. If the contractor/provider is uncertain whether a woman meets citizenship and alienage status, the completed medical assistance form should be forwarded to the DHS for processing and determination. When citizenship and alienage is in question, the woman is not presumptively eligible.

Question 19. What happens if there is uncertainty about a client's legal immigration status?

Answer. Contractor/provider may complete and forward the medical assistance application to DHS for an eligibility determination. Attach a copy of the woman's immigration card, if available. She will have to provide it for the determination to be completed.

Question 20. What supporting documentation should be attached to the Form 1034?

Answer. Refer to questions 17 and 18 in this document for BCCCP requirements. Further, in order to be eligible for Medicaid, the DHS requires proof of income, residency and citizenship.

Question 21. For auditing purposes, what documentation /proofs are required to be in the patient's medical record besides the 1034 form?

Answer. BCCCP requires documentation of all medical screening, diagnostic procedures leading to a cancer diagnosis and initiation of treatment (case management). The BCCCP does not require that a copy of the 1034 be maintained in the medical record.

Question 22. Is the BCCCP going to create a policy for the agencies to follow when screening the patient for presumptive eligibility?

Answer. Yes, BCCCP has a policy for BCCCP contractors/providers. The BCCCP reviewed this policy and implementation procedures with all BCCCP contractors. The policy and procedures for BCCCP contractors to follow are posted on the BCCCP Web Site and will be added to the revised Manual of Operations.

Question 23. Could you elaborate more on the treatment of cervical cancer? After completion of a Leep or Cryotherapy would follow-up Paps be considered treatment or monitoring? Please advise and would the same principle apply with the 90 days previously?

Answer. Refer to question 4 in this document for what is considered active "treatment." Follow-up procedures are covered by Medicaid, under the Treatment Act, only if the woman is in active treatment. Paps that occur after treatment (Leep or Cryotheraphy procedures) would be considered routine monitoring services and can be covered by the BCCCP. The same principle applies during the previous 90 days.

Question 24. Are follow-up visits covered as part of treatment? For example, after chemotherapy and radiation, a woman is given instructions to follow-up every 3 months with her oncologist for two years. During that time, follow-up mammograms and CT scans are also ordered.

Answer. Refer to question 4 and 23 in this document for what is considered active "treatment."

Question 25. We attempted to contact all of our clients who were diagnosed with cancer in 2002 in order to send their applications in before the end of December. However, there were a couple which had moved and we could not reach, but who eventually either had letters/messages forwarded to them or heard about the Treatment Act through third parties and called us. How do we handle those clients? These are people who were in treatment at least after September 1, 2002.

Answer. Continue to follow the BCCCP case management process, including providing appropriate referral to nearest BCCCP contractor and treatment resources.

Question 26. A woman was diagnosed in 1999 with breast cancer by a non-BCCCP provider and discontinued active cancer treatment before the end of prescribed treatment. The woman is now seeking screening from a BCCCP provider. Is she eligible for Medicaid services under the Treatment Act?

Answer. Refer to question 1 in this document for eligibility requirements. A woman diagnosed by a non-BCCCP contractor/provider and who received active treatment for cancer would not be eligible for Medicaid services under the Treatment Act.

Question 27. Is Tamoxifen a Medicaid covered service?

Answer. Tamoxifen is a standard part of therapy for breast cancer for women with estrogen receptor-positive tumors. The typical duration of Tamoxifen treatment for such patients is five years following the end of the first phase of therapy, which may include surgery, radiation, and chemotherapy. This first phase begins after initial diagnosis. This approach is considered standard of care in the oncology community, and is based upon solid medical evidence.

From this standpoint, for women with estrogen receptor-positive tumors, up to five years of Tamoxifen therapy following completion of the first phase of treatment is regarded as part of ongoing, active therapy. The Medicaid program regards this use of Tamoxifen as continued active therapy, medically necessary, and not "prevention."

Question 29. How does DHS go about paying previous unpaid medical bills?

Answer. DHS does not request proof of unpaid medical bills in prior months at the time that the 1034 form is submitted. DHS does not want to hold up the application process for current benefits while the bills are being obtained. However, after submission of the 1034 form, the BCCCP contractor/providers should submit prior unpaid medical bills to DHS.

Question 30. If the woman has submitted the documents to become a citizen; however, the citizenship is still pending is she eligible?

Answer. Refer to question 10 in this document for citizenship status. The woman may have a qualifying alien status. Alien eligibility depends on a number of factors including entry date, status and the immigration card held. There are also exceptions made for military connection and certain groups of entrants. DHS must see a copy of the alien registration card and validate it using an electronic interface that DHS has with Immigration and Naturalization Services (INS). Non-citizens cannot be presumptively eligible. DHS must complete the determination of qualifying status before certifying the woman.

Question 31. If the woman has a social security card for the purposes of work only, is she considered a citizen?

Answer. No.

Question 32. What would constitute an emergency medical condition?

Answer. Refer to question 11 and 12 in this document for definition of emergency medical condition. BCCCP contractor/provider must submit the application to DHS for emergency medical determination as defined by the Texas Medicaid program.

Question 33. Does a woman qualify for Medicaid services under the Treatment Act if she is on Medicaid spend down?

Answer. Yes, DHS has a process for extending coverage for the remainder of the spend down month, if the woman qualifies for that month.

Question 34. Is Medicaid spend down a creditable insurance?

Answer. No.

Question 35. Can the contractor receive an electronic copy of the application?

Answer. DHS does not plan to make the copy available electronically.

Question 36. Will Tamoxifen be covered as a preventative? For example a woman is put on Tamoxifen for 5 years after chemotherapy and radiation.

Answer. In the strictest sense, prevention or prophylaxis are best defined as steps that are taken to avoid the onset of disease. Tamoxifen is a standard part of therapy for breast cancer for women with estrogen receptor-positive tumors. From this standpoint, for women with estrogen receptor-positive tumors, up to five years of Tamoxifen therapy following completion of the first phase of treatment is regarded as part of ongoing, active therapy. The Medicaid program regards this use of Tamoxifen as continued active therapy, medically necessary, and not "prevention."

Question 37. What pre-cancerous and cancer conditions are covered by Medicaid under the Treatment Act?

Answer. The BCCCP considers biopsy-confirmed CINIII, severe dysplasia, carcinoma in–situ, invasive cervical cancer, and invasive breast cancer as qualifying diagnoses for Medicaid eligibility under the Treatment Act.